

Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
4436									
CERTIFICATE OF DEATH									
Reg. Dist. No. 04425									
1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City (Rural)</u>					c. LENGTH OF STAY IN lb <u>68 yrs</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Centennial Road</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>William S. BOARDLEY</u>					4. DATE OF DEATH Month <u>4</u> Day <u>2</u> Year <u>1959</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 9, 1890</u>		9. AGE (In years last birthday) <u>68</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME <u>Aaron Boardley</u>					14. MOTHER'S MAIDEN NAME <u>Sarah M. Kelly</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <u>INFORMANT</u>				
17. ADDRESS <u>Centennial Road, Ellicott City, Md</u>					18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>CONGESTIVE HEART FAILURE</u> (c) <u>ATHEROSCLEROSIS</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 year</u> <u>CHRONIC</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PROSTATIC CARCINOMA</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>					20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>MAY</u> , 19 <u>58</u> , to <u>APRIL 2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>MARCH 31</u> , 19 <u>59</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Donald E. Fisher</u>					ADDRESS (Street, city or town, state) <u>Ellicott City, Md</u> DATE SIGNED <u>4-2-59</u>				
PHYSICIAN'S NAME (Type) <u>Donald E. Fisher</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-6-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brown's Chapel, Dayton, Md</u>		22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Saunden</u> ADDRESS <u>Rockville, Md.</u>					24a. REC'D BY REGISTRAR <u>APR 7 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		

CERTIFICATE OF DEATH

1938

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4437

## CERTIFICATE OF DEATH

04426

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Howard</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkridge</b> c. LENGTH OF STAY IN 1b <b>Elkridge</b> d. NAME OF HOSPITAL (If not in hospital, give street address) <b>6437 Old Washington Blvd</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkridge</b> d. STREET ADDRESS <b>6437 Old Washington Blvd</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARY L CARLL</b> First Middle Last		4. DATE OF DEATH Month Day Year <b>April 11, 1959</b> 19	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 19, 1878</b>
9. AGE (In years last birthday) <b>80</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry C. Smith</b>		14. MOTHER'S MAIDEN NAME <b>Mary Wolbert</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>none</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Henry Carll, 113 Oak Dr. Catonsville 28</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Disease</b> <b>420.1</b> DUE TO <b>Chronic Myocarditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterial Hypertension</b> (c) <b>1942</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1942</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1942</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 10, 1959</b> to <b>April 11, 1959</b> , that I last saw the deceased alive on <b>April 10, 1959</b> , and that death occurred at <b>5:00 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>B B Brumbaugh</b> M.D.		ADDRESS (Street, city or town, state) <b>Elkridge Md</b> DATE SIGNED <b>4/11/59</b>	
PHYSICIAN'S NAME (Type) <b>B B Brumbaugh</b>		<b>Elkridge Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/14/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard 4107 Wilkens Ave.</b>		24a. REC'D BY REGISTRAR <b>APR 14 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04427

4438

1. PLACE OF DEATH a. COUNTY <b>Howard</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN 1b <b>3 Vol. 4</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S.Rt. 1 at Laurel Race Track Entrance</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>3003 W. Coldspring Lane</b> d. STREET ADDRESS <b>3003 W. Coldspring Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LOTTIE</b> Middle <b>BEATRICE</b> Last <b>GARNER</b>		4. DATE OF DEATH Month <b>April</b> Day <b>1</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 4, 1898</b>
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Buyer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. Store</b>	
11. BIRTHPLACE (State or foreign country) <b>Balto. County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Fishpaw</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Mary Jamison</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>Mr. Ernest Gill, 3003 W. Cold Spring Lane</b>	
17. INFORMANT <b>Mr. Ernest Gill, 3003 W. Cold Spring Lane</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple extreme injuries</b> <b>816X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Auto &amp; tractor-trailer collision</b>	
20c. TIME OF INJURY Month, Day, Year <b>12:30 p. m. 4/1 1959</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Road</b>		20f. (City or town) (County) (State) <b>Howard Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Russell S. Fisher</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/4/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery,</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville, Balto. Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Vernon Lemmon</b>		24a. REC'D BY REGISTRAR <b>APR 3 '59</b>	
ADDRESS <b>4611 Park Heights, Balto. Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Fisher</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
443 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04428

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard County,</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Mt. Airy</u>		c. LENGTH OF STAY IN 1b <u>24 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>-</u>		d. STREET ADDRESS <u>RFD #3</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clarence Luther Hatfield</u>		4. DATE OF DEATH Month Day Year <u>April 16 19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 27, 1889</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>69</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Alice Hatfield</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-20-7612</u>	
17. INFORMANT <u>Geneva Hatfield, wife, Mt. Airy, R D #3.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic-hypertensive cardio-vascular disease</u> DUE TO (c) <u>420.1</u> stopping the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Thomas F. Herbert</u>		DATE SIGNED <u>4-17-59</u>	
EXAMINER'S NAME (Type) <u>Thomas F. Herbert, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-19-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Louise Grove</u>		22d. LOCATION (City, town, or county) (State) <u>Fredrick Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz</u>		ADDRESS <u>Winfield, Md.</u>	
24a. REC'D BY REGISTRAR <u>APR 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Archie S. Thomas</u>	

MEDICAL CERTIFICATION





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4440

CERTIFICATE OF DEATH

04429

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> by COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Mount Airy</u>		c. LENGTH OF STAY IN 1b <u>15 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Watersville Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ervine</u> Middle <u>Ronella</u> Last <u>Jones</u>		4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 12, 1901</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Edwin Gassoway</u>		14. MOTHER'S MAIDEN NAME <u>Miranda Myers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-05-2500</u>	
17. INFORMANT <u>Mrs. Helen Hoy - Mt. Airy, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Abdominal + Pulmonary Carcinomatosis</u> 180x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hyper nephroma</u> DUE TO (c) <u>4 months</u>		INTERVAL BETWEEN ONSET AND DEATH <u>several weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>February 4, 1959</u> , to <u>April 9, 1959</u> , that I last saw the deceased alive on <u>April 9, 1959</u> , and that death occurred at <u>6:50 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.B. Culwell</u> M.D.		ADDRESS (Street, city or town, state) <u>Mt. Airy, Md.</u>	
PHYSICIAN'S NAME (Type) <u>W.B. Culwell</u>		DATE SIGNED <u>4/9/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-13-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G.M. Waltz</u> ADDRESS <u>Winfield, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 13 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Friend</u>	

CERTIFICATE OF DEATH

1950

PLACE ON BACK CERTIFICATE		MAYLAND	
1. DATE OF DEATH 10/10/50		2. TIME OF DEATH 10:00 AM	
3. PLACE OF DEATH HOME		4. NAME OF DECEASED JOHN J. SMITH	
5. SEX M		6. AGE 65	
7. RACE W		8. OCCUPATION Carpenter	
9. MARITAL STATUS M		10. CAUSE OF DEATH Heart Disease	
11. MANNER OF DEATH N		12. SIGNATURE OF PHYSICIAN J. H. BROWN	
13. SIGNATURE OF REGISTRAR J. H. BROWN		14. SIGNATURE OF DECEASED JOHN J. SMITH	
15. SIGNATURE OF WITNESS J. H. BROWN		16. SIGNATURE OF DECEASED JOHN J. SMITH	
17. SIGNATURE OF DECEASED JOHN J. SMITH		18. SIGNATURE OF DECEASED JOHN J. SMITH	
19. SIGNATURE OF DECEASED JOHN J. SMITH		20. SIGNATURE OF DECEASED JOHN J. SMITH	
21. SIGNATURE OF DECEASED JOHN J. SMITH		22. SIGNATURE OF DECEASED JOHN J. SMITH	
23. SIGNATURE OF DECEASED JOHN J. SMITH		24. SIGNATURE OF DECEASED JOHN J. SMITH	
25. SIGNATURE OF DECEASED JOHN J. SMITH		26. SIGNATURE OF DECEASED JOHN J. SMITH	
27. SIGNATURE OF DECEASED JOHN J. SMITH		28. SIGNATURE OF DECEASED JOHN J. SMITH	
29. SIGNATURE OF DECEASED JOHN J. SMITH		30. SIGNATURE OF DECEASED JOHN J. SMITH	
31. SIGNATURE OF DECEASED JOHN J. SMITH		32. SIGNATURE OF DECEASED JOHN J. SMITH	
33. SIGNATURE OF DECEASED JOHN J. SMITH		34. SIGNATURE OF DECEASED JOHN J. SMITH	
35. SIGNATURE OF DECEASED JOHN J. SMITH		36. SIGNATURE OF DECEASED JOHN J. SMITH	
37. SIGNATURE OF DECEASED JOHN J. SMITH		38. SIGNATURE OF DECEASED JOHN J. SMITH	
39. SIGNATURE OF DECEASED JOHN J. SMITH		40. SIGNATURE OF DECEASED JOHN J. SMITH	
41. SIGNATURE OF DECEASED JOHN J. SMITH		42. SIGNATURE OF DECEASED JOHN J. SMITH	
43. SIGNATURE OF DECEASED JOHN J. SMITH		44. SIGNATURE OF DECEASED JOHN J. SMITH	
45. SIGNATURE OF DECEASED JOHN J. SMITH		46. SIGNATURE OF DECEASED JOHN J. SMITH	
47. SIGNATURE OF DECEASED JOHN J. SMITH		48. SIGNATURE OF DECEASED JOHN J. SMITH	
49. SIGNATURE OF DECEASED JOHN J. SMITH		50. SIGNATURE OF DECEASED JOHN J. SMITH	
51. SIGNATURE OF DECEASED JOHN J. SMITH		52. SIGNATURE OF DECEASED JOHN J. SMITH	
53. SIGNATURE OF DECEASED JOHN J. SMITH		54. SIGNATURE OF DECEASED JOHN J. SMITH	
55. SIGNATURE OF DECEASED JOHN J. SMITH		56. SIGNATURE OF DECEASED JOHN J. SMITH	
57. SIGNATURE OF DECEASED JOHN J. SMITH		58. SIGNATURE OF DECEASED JOHN J. SMITH	
59. SIGNATURE OF DECEASED JOHN J. SMITH		60. SIGNATURE OF DECEASED JOHN J. SMITH	
61. SIGNATURE OF DECEASED JOHN J. SMITH		62. SIGNATURE OF DECEASED JOHN J. SMITH	
63. SIGNATURE OF DECEASED JOHN J. SMITH		64. SIGNATURE OF DECEASED JOHN J. SMITH	
65. SIGNATURE OF DECEASED JOHN J. SMITH		66. SIGNATURE OF DECEASED JOHN J. SMITH	
67. SIGNATURE OF DECEASED JOHN J. SMITH		68. SIGNATURE OF DECEASED JOHN J. SMITH	
69. SIGNATURE OF DECEASED JOHN J. SMITH		70. SIGNATURE OF DECEASED JOHN J. SMITH	
71. SIGNATURE OF DECEASED JOHN J. SMITH		72. SIGNATURE OF DECEASED JOHN J. SMITH	
73. SIGNATURE OF DECEASED JOHN J. SMITH		74. SIGNATURE OF DECEASED JOHN J. SMITH	
75. SIGNATURE OF DECEASED JOHN J. SMITH		76. SIGNATURE OF DECEASED JOHN J. SMITH	
77. SIGNATURE OF DECEASED JOHN J. SMITH		78. SIGNATURE OF DECEASED JOHN J. SMITH	
79. SIGNATURE OF DECEASED JOHN J. SMITH		80. SIGNATURE OF DECEASED JOHN J. SMITH	
81. SIGNATURE OF DECEASED JOHN J. SMITH		82. SIGNATURE OF DECEASED JOHN J. SMITH	
83. SIGNATURE OF DECEASED JOHN J. SMITH		84. SIGNATURE OF DECEASED JOHN J. SMITH	
85. SIGNATURE OF DECEASED JOHN J. SMITH		86. SIGNATURE OF DECEASED JOHN J. SMITH	
87. SIGNATURE OF DECEASED JOHN J. SMITH		88. SIGNATURE OF DECEASED JOHN J. SMITH	
89. SIGNATURE OF DECEASED JOHN J. SMITH		90. SIGNATURE OF DECEASED JOHN J. SMITH	
91. SIGNATURE OF DECEASED JOHN J. SMITH		92. SIGNATURE OF DECEASED JOHN J. SMITH	
93. SIGNATURE OF DECEASED JOHN J. SMITH		94. SIGNATURE OF DECEASED JOHN J. SMITH	
95. SIGNATURE OF DECEASED JOHN J. SMITH		96. SIGNATURE OF DECEASED JOHN J. SMITH	
97. SIGNATURE OF DECEASED JOHN J. SMITH		98. SIGNATURE OF DECEASED JOHN J. SMITH	
99. SIGNATURE OF DECEASED JOHN J. SMITH		100. SIGNATURE OF DECEASED JOHN J. SMITH	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND IS NOT VALID FOR ANY OTHER PURPOSES.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4441 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04430

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Howard County</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8 Mary Beth Way</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> <span style="float: right;">b. COUNTY <b>Howard</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b> d. STREET ADDRESS <b>8 Mary Beth Way</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Roland F.</b> Middle <b>Kasemeyer</b> Last <b>Roland F. Kasemeyer</b>				<b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>5</b> Year <b>1959</b>											
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>W</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Sept. 26/13</b>		<b>9. AGE</b> (In years last birthday) <b>45</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Supt.</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Standard Oil Co. N.J.</b>				<b>11. BIRTHPLACE</b> (State or foreign country) <b>Balto. Md.</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>			
<b>13. FATHER'S NAME</b> <b>Frederick Kasemeyer</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Margaret Rollman</b>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)				<b>16. SOCIAL SECURITY NO.</b> <b>214 01 5784</b>				<b>17. INFORMANT</b> Address <b>Mrs. Mary E. Kasemeyer, Ellicott City, Md.</b>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
<b>ACTUAL SIGNATURE</b> <i>Thomas F. Herbert</i>						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>						<b>DATE SIGNED</b> <b>April 5, 1959</b>			
<b>EXAMINER'S NAME (Type)</b> <b>Thomas F. Herbert, M.D.</b>						<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>									
<b>22b. DATE THEREOF</b> <b>April 9/59</b>				<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Loudon Park</b>				<b>22d. LOCATION (City, town, or county)</b> (State) <b>Baltimore 29 Md.</b>							
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Witzke Funeral Directors</b> <b>4101 E. Amundson Ave.</b>						<b>24a. REC'D BY REGISTRAR</b> <b>APR 5 1959</b> <b>DATE</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Thoms</i>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

REPORT

Edward Hootner

Wilcox, Md.

Wilcox, Md.

2 Mary Beth Way

2 Mary Beth Way

April 2/59

Robert J. Kuehn

Sept. 25/58

Sept. 25/58

10

MA

Sept. 25/58

Sept. 25/58

10

Mary Beth Hootner

Mary Beth Hootner

211 N. 5th St. Mary E. Hootner, Wilcox, Md.

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

04431

Reg. Dist. No.

4442

1. PLACE OF DEATH a. COUNTY <u>Howard</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenwood</u>		c. LENGTH OF STAY IN 1b <u>X</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenwood</u>		d. STREET ADDRESS <u>Burnt Wood Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Virginia</u>		First <u>Virginia</u>		Middle <u>KIMBERLIN</u>		Last <u>KIMBERLIN</u>		4. DATE OF DEATH Month <u>April</u> Day <u>14</u> Year <u>1959</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 12, 1871</u>		9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u>88</u>		IF UNDER 24 HRS. Days <u>88</u> Hours <u>88</u> Min. <u>88</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>Virginia</u>			
13. FATHER'S NAME <u>Henry Foglesong</u>						14. MOTHER'S MAIDEN NAME <u>Mary Rose</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Miss Nettie Kimberlin, Glenwood, Md</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocardial failure</u> 421.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Mitral insufficiency &amp; coronary sclerosis</u> DUE TO (c) <u>25 years</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Nephrosclerosis with uremia</u>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I attended the deceased from <u>August 28, 1946</u> , to <u>April 14, 1959</u> , that I last saw the deceased alive on <u>April 13, 1959</u> , and that death occurred at <u>2:00 A.M.</u> from the causes and on the date stated above.													
ACTUAL SIGNATURE <u>Charles S. Whitaker, M.D.</u>				ADDRESS (Street, city or town, state) <u>Clarksville, Maryland</u>				DATE SIGNED <u>4-14-59</u>					
PHYSICIAN'S NAME (Type) <u>Charles S. Whitaker, M.D.</u>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-16-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove</u>				22d. LOCATION (City, town, or county) <u>Glenwood, Md</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Higinbotham, Ellicott City, Md</u>						ADDRESS <u>Ellicott City, Md</u>		24a. REC'D BY REGISTRAR DATE <u>APR 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1943



Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.



4443  
CERTIFICATE OF DEATH

04432

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Howard</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>				c. LENGTH OF STAY IN 1b <b>3 yrs-7mos</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>3V01-4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Taylor Manor Hospital</b>				d. STREET ADDRESS <b>3743 Park Heights Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Julius</b> Middle <b>Klavens</b> Last				4. DATE OF DEATH Month <b>April</b> Day <b>18</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 31, 1884</b>	
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tailor</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Russia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Abraham</b>				14. MOTHER'S MAIDEN NAME <b>Leva</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>215-10-5317</b>		17. INFORMANT <b>Ida Klavens - Bone</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial failure</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, general, severe</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chr. brain syndrome with psychosis due to arteriosclerosis; decubitus ulcers</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>  <b>years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Sept 26</b> , 19 <b>55</b> , to <b>April 18</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>April 18</b> , 19 <b>59</b> , and that death occurred at <b>5:05 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Taylor Manor Hospital</b> <b>4/18/59</b>							
ACTUAL SIGNATURE <b>Stephen Lee Magnus</b>				M.D. <b>Taylor Manor Hospital</b>			
PHYSICIAN'S NAME (Type) <b>Taylor Manor Hospital, Ellicott City, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>4-19-1959</b>		<b>Washington D.C.</b>		<b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Lewis Inc - 2100 Eastern Ave</b>				24a. REC'D BY REGISTRAR DATE <b>APR 20 '59</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Stone</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04433

4444

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Howard</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Mt. Airy</b>		c. LENGTH OF STAY IN 1b <b>years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.F.D. # 3, Mt. Airy</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>F.</b> Last <b>Molesworth</b>		4. DATE OF DEATH Month <b>April</b> Day <b>5</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 7, 1875</b>
9. AGE (In years lost birthday) <b>83 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hostler</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O. Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Asbury Molesworth</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Diffy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Mrs Mildred Murphy, Cullen, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>156.1</b> IMMEDIATE CAUSE (a) <b>Carcinoma of Liver with</b> DUE TO <b>General Metastasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>DUE TO</b> (c) <b>DUE TO</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 mo</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Mar 5, 1959</b> , to <b>Apr 5, 1959</b> , that I last saw the deceased alive on <b>Apr 5, 1959</b> , and that death occurred at <b>8:15 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Mt Airy Md</b> DATE SIGNED <b>4-6-59</b>			
ACTUAL SIGNATURE <b>C M Van Poole</b>		M.D. <b>Mt Airy Md</b>	
PHYSICIAN'S NAME (Type) <b>C M Van Poole</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/8/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Montgomery Meth.</b>		22d. LOCATION (City, town, or county) (State) <b>Clagetsville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Chas P. Molesworth</b>		ADDRESS <b>Damascus, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>APR 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hays</b>	

# CERTIFICATE OF DEATH

STATE OF MARYLAND - BALTIMORE, MD.

NAME OF DECEASED JAMES E. JOHNSON		DATE OF BIRTH April 5, 1908		PLACE OF BIRTH Baltimore, Md.	
MARRIAGE None		EDUCATION None		OCCUPATION None	
SEX Male		RACE Negro		RELIGION None	
MOTHER'S NAME Mary E. Johnson		FATHER'S NAME James E. Johnson		DATE OF DEATH April 5, 1908	
PLACE OF DEATH Baltimore, Md.		CAUSE OF DEATH None		MANNER OF DEATH None	
SIGNATURE OF DECEASED None		SIGNATURE OF WITNESS None		SIGNATURE OF PHYSICIAN None	
DATE OF SIGNATURE None		DATE OF SIGNATURE None		DATE OF SIGNATURE None	
PLACE OF SIGNATURE None		PLACE OF SIGNATURE None		PLACE OF SIGNATURE None	
NAME OF PHYSICIAN None		NAME OF SURGEON None		NAME OF MIDWIFE None	
DATE OF SIGNATURE None		DATE OF SIGNATURE None		DATE OF SIGNATURE None	
PLACE OF SIGNATURE None		PLACE OF SIGNATURE None		PLACE OF SIGNATURE None	
NAME OF PHYSICIAN None		NAME OF SURGEON None		NAME OF MIDWIFE None	
DATE OF SIGNATURE None		DATE OF SIGNATURE None		DATE OF SIGNATURE None	
PLACE OF SIGNATURE None		PLACE OF SIGNATURE None		PLACE OF SIGNATURE None	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1, 2 Film G242 5-18-59 et  
4445  
CERTIFICATE OF DEATH

04434

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Howard</u> <u>Baltimore</u>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Highland Fulton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Highland Baltimore 7 03 x 2</u>											
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Simons Nursing Home</u>				d. STREET ADDRESS <u>1520 Ingleside, Zone 7</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First <u>STELLA</u> Middle <u>MOSHER</u> Last				4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>1959</u>											
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1879 ?</u>		9. AGE (In years last birthday) <u>80 ?</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>				11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Nursing Home Records</u> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>446X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Nephrosclerosis</u> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>5 years</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>4-8-</u> <u>1954</u> , to <u>4-22-</u> <u>1959</u> , that I last saw the deceased alive on <u>4-21-</u> <u>1959</u> , and that death occurred at <u>1:00 P.M.</u> , from the causes and on the date stated above.															
ACTUAL SIGNATURE <u>Charles S. Whitaker</u> M.D.				ADDRESS (Street, city or town, state) <u>Clarksville, Maryland</u>				DATE SIGNED <u>4-23-59</u>							
PHYSICIAN'S NAME (Type) <u>Charles S? Whitaker, M.D.</u>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>4-24-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>				22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Higginbotham, Ellicott City, Md</u> ADDRESS						24a. REC'D BY REGISTRAR <u>APR 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>							

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH	
JAMES H. HARRIS		Male		45		White		10-15-1900	
6. PLACE OF BIRTH		7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. DATE OF DEATH	
Baltimore, Md.		Baltimore, Md.		Heart Disease		Natural		10-20-1945	
11. OCCUPATION		12. EDUCATION		13. MARITAL STATUS		14. RELIGION		15. SIGNATURE OF REGISTRAR	
None		None		Married		Catholic		[Signature]	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF WITNESS		18. SIGNATURE OF PHYSICIAN		19. SIGNATURE OF CLERK		20. SIGNATURE OF JUDGE	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

TO BE FILLED BY THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND. THIS FORM IS TO BE FILED IN THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THIS FORM IS COMPLETED AND FILED IN THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THIS FORM IS COMPLETED AND FILED IN THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4446

## CERTIFICATE OF DEATH

04435

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural--Mt. Airy</u>		c. LENGTH OF STAY IN TB <u>33 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HOWARD</u> First Middle Last <u>R. POOLE</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>11</u> Year <u>19 59</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-13-1887</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>general</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Poole</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Hall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-16-6635</u>	
17. INFORMANT <u>Mrs. Pauline Poole, same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>generalized arteriosclerosis, cardiac</u> (c) <u>failure, chronic</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1956 to 11 April 59</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19 56</u> 19 <u>59</u> , to <u>11 April</u> 19 <u>59</u> , that I last saw the deceased alive on <u>11 April</u> 19 <u>59</u> , and that death occurred at <u>12:45</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.		ADDRESS (Street, city or town, state) <u>Agawam, Md.</u> DATE SIGNED <u>13 April 59</u>	
PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4-14-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Taylorsville</u>	22d. LOCATION (City, town, or county) (State) <u>Carroll Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz,</u> ADDRESS <u>Winfield, Md.</u>		24a. RECEIVED BY REGISTRAR DATE <u>APR 15 59</u>	
24b. REGISTRAR'S SIGNATURE <u>William E. Thomas</u>			

CERTIFICATE OF DEATH

2468

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 45	
4. DATE OF DEATH April 11, 1926		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Myocardial Infarction		8. DISEASE OR INJURY Coronary Artery Disease		9. PREVIOUS ILLNESS Hypertension	
10. SIGNATURE OF PHYSICIAN J. H. Harris		11. SIGNATURE OF WITNESS J. H. Harris		12. SIGNATURE OF DECEASED J. H. Harris	
13. SIGNATURE OF REGISTRAR J. H. Harris		14. SIGNATURE OF CLERK J. H. Harris		15. SIGNATURE OF JURY J. H. Harris	

James H. Harris, Baltimore  
Myocardial Infarction, Coronary  
Artery Disease, Hypertension.

April 11, 1926  
J. H. Harris  
J. H. Harris  
J. H. Harris

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04436

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Howard</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>West Friendship</b>		c. LENGTH OF STAY IN 1b <b>83X-3</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b>		b. COUNTY <b>Augusta</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Staunton</b>		d. STREET ADDRESS <b>317 E. Hampton St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EUGENE TAYLOR REED</b>		First		Middle		Last		4. DATE OF DEATH <b>4-7-59</b>		Month		Day		Year <b>19</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 6 1909</b>		9. AGE (in years last birthday) <b>49</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Trucking</b>				11. BIRTHPLACE (State or foreign country) <b>Virginia</b>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Walter Reed</b>						14. MOTHER'S MAIDEN NAME <b>Mary Lucas</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>225-24-4506</b>		17. INFORMANT <b>Janet Hildebrand, Staunton, Va.</b>		Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carbon Monoxide Poisoning</b> <b>9773.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____												INTERVAL BETWEEN ONSET AND DEATH <b>15 Min.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Taped hose to exhaust pipe into car</b>											
20c. TIME OF INJURY Hour a. m. <b>6:45 AM</b>				Month, Day, Year <b>4-7-59 19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Nat while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>Live Stock Market</b>		20f. (City or town) <b>West Friendship</b>		(County) <b>Howard</b>		(State) <b>Md</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <b>George E. Burgtorf</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>April 7, 1959</b>							
EXAMINER'S NAME (Type) <b>George E. Burgtorf M D</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>4-10-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Brethren Church</b>				22d. LOCATION (City, town, or county) <b>Mc Kinley, Va</b>				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md</b>						ADDRESS		24a. REC'D BY REGISTRAR <b>APR 9 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hane</b>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4448

## CERTIFICATE OF DEATH

04437

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fulton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> 16-17-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Simons Rest Home</u>		d. STREET ADDRESS <u>324 Prince Geo. St</u>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>WRIGHT</u> Last <u>WRIGHT</u>		4. DATE OF DEATH Month <u>April</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 11, 1897</u> 82 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	9. AGE (In years last birthday) <u>62</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Reinhold</u>		14. MOTHER'S MAIDEN NAME <u>Mary Frances Andrews</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Mrs. Lily Phelps</u> Address <u>324 Pr. Geo. St Laurel Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocardial failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>15 years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebrovascular accident with right hemiplegia</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 5, 1959</u> to <u>April 6, 1959</u> , that I last saw the deceased alive on <u>April 3, 1959</u> , and that death occurred at <u>11:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles S. Whitaker</u> M.D.		ADDRESS (Street, city or town, state) <u>Clarksville, Maryland</u> DATE SIGNED <u>4-7-59</u>	
PHYSICIAN'S NAME (Type) <u>Charles S. Whitaker, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 9, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Choptank Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Choptank, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Se Will Sanderson</u> ADDRESS <u>Laurel, Md</u>		24a. REC'D BY REGISTRAR DATE <u>APR 10 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Phelps</u>

MEDICAL CERTIFICATION

I

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

